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Does Violence Breed Violence? Contributions from a Study of the Child Abuse Syndrome

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A study covering three generations of families of abused children supports the themes that violence breeds violence and that a child who experiences violence as a child has the potential of becoming a violent member of society in the future. The authors believe that the physician has a critical role and responsibility in interrupting this cycle of violence.

> These violent delights have violent ends,
> and in their triumph die.
> *Romeo and Juliet,* II, vi, 9.

IN 1963 Curtis(2) wrote a brief clinical note entitled "Violence Breeds Violence —Perhaps?" In this report he discussed the battered child syndrome and expressed the concern that " . . . children so treated . . . [may] become tomorrow's murderers and perpetrators of other crimes of violence, if they survive." He further felt that an abused child:

> should have an unusual degree of hostility toward the parents and toward the world in general. The control and channelling of this hostility into nondestructive avenues of release would pose a problem both for the child and for society. In addition, the child would be presented with parental objects for identification who provided an example of the destructive and relatively uncontrolled release of hostile aggression.

As support for this concept, he referred to the studies of Duncan and Easson and Steinhilber(3, 4). Duncan, in a report of a preliminary study of six male adult prisoners convicted of first-degree murder, noted that all were from middle class families of good social standing. He observed that the most striking feature of four of these cases was continuous, remorseless brutality suffered during childhood at the hands of one parent in the face of compliant acquiescence of the other. The remaining two prisoners were overtly psychotic, and no such childhood history was obtained.

Easson and Steinhilber, in a brief clinical account of eight boys who had made murderous assaults—one of them successful—noted that all were from socially acceptable "normal" families. In two of these cases there was a clear history of habitual brutal beating by a parent, and the histories of three others contained remarks that "lead one to wonder if brutality to the child was being concealed."

As members of the Child Abuse Research Group of the Children's Hospital of the District of Columbia as well as participating members of a community-wide interagency committee to plan and coordinate procedures for handling these cases of child abuse, the authors had an opportunity to further investigate the probability that violence breeds violence.

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Procedure

In June of 1963, shortly after Kempe and colleagues(5) reported their nationwide survey that revealed the prevalence of the battered child syndrome, the Children's Hospital of the District of Columbia initiated administrative procedures for reporting all cases of suspected or proven child abuse. Under hospital policy, the director of social service was responsible for submitting a monthly report to the administrator naming and summarizing such cases. In addition, this director was the liaison and referring agent between the hospital and the responsible community agency, the Women's Bureau of the Metropolitan Police Department of the District of Columbia(10).

The records from the social service department of the hospital were obtained on all cases referred by attending physicians in the emergency room, outpatient clinic, or hospital wards from June through December of 1963. In 1967, the authors reviewed in retrospect this group of 34 cases in order to study the families of these cases as well as the community agency involvements both before, at the time of, and for the four-year period following the incident that precipitated the report.

The Women's Bureau of the D. C. Police Department and the protective service section of the child welfare division of the Department of Public Welfare permitted the authors to read all of the existing records in their agency on the cases under study. Through the cooperation of the Family and Child Services of the District of Columbia, a private agency, and the Social Service Department of the Juvenile Court of the District of Columbia, a similar review of records on the cases in the series was possible.

The Children's Hospital records and the files of the cooperating agencies not only provided information on their contacts with these children and their families from 1963 until the study in 1967, but also yielded valuable historical data on many of the families, dating back as far as 20 years before the reported incident of child abuse.

Observations

The study of the 34 cases reflected the frequency of abusive behavior in such families. In more than half of the cases, abuse on the part of one or both parents toward each other or at siblings was found. Of the 19 cases in which siblings were abused, 15 were in families where the child under study had a history of abuse prior to the 1963 episode. The records of the hospital and associated agencies showed that more than one episode of abusive behavior toward the child had occurred in 20 of the 34 cases. Even after referral to community services, abuse or neglect continued or recurred in 12 cases during the four-year period reviewed in the study. This observation of general abusive behavior in these families, rather than selective abuse to a specific child, differs from the "one child in a family" observations of Merrill(6), Zalba(11), and Boardman(1).

Case Reports

In four of the cases there was sufficient evidence to show that the abuser had been abused as a child.

Case 1. W. S., a six-month-old girl, was brought to the emergency room because her mother had knocked her unconscious. The father reported a similar episode previously; however, he had not brought the child in at that time. Information from the Women's Bureau revealed that the mother had been abused by her mother as a child and had been known to the police department since her early teens because of alcoholism and disorderly conduct.

Case 2. E. R. was brought to the emergency room by his father, who complained that the mother had beaten this two-month-old child. In addition to clinical evidence of soft tissue injury, the child showed evidence of neglect (diaper rash, weight loss). The Women's Bureau records noted that the mother had been abused by her father as a child, and she had been known to the police department since her early teens because of alcoholism, assaultive behavior, and disorderly conduct. On the first day following hospitalization of the child, his mother removed him without medical approval. The Women's Bureau went to the home and returned the child to the hospital. On readmission, a fractured skull that had not been present at the time of the original admission was noted.

Case 3. A. T., a six and one-half-year-old child, observed in the emergency room, was

found to have multiple hematomas, welts, and contusions. History revealed that the father had beaten the child with a belt. Records showed that the father had been abused as a child, and he was described as violent and abusive to his wife and to the other five siblings. Two months after the event described above, the child was seen in the emergency room after a similar beating; at this time he was noted to have torticollis. Follow-up reports note that four years after the initial event the child was enuretic and had phobias.

Case 4. V. B., a one-year-old child, was seen in the emergency room after a neighbor's complaint led the police to the child's house. He was found alone in a dirty and disorganized house; the refrigerator was broken, and gas fumes were in the room. Clinical evidence of neglect was noted. Women's Bureau records showed that the mother, as a child, had a history of running away from home because of her fear of being beaten by her mother. She had been known to the police department since childhood because of truancy, petty larceny, disorderly conduct, and assaultive behavior. During the four years after the initial episode, reports revealed abusive behavior and neglect toward all five children. One sibling died 14 months after the above incident because of "diarrhea"; another sibling was burned while playing with matches two and one-half years after the initial incident.

At the time of the study, four years after the initial reporting of abusive behavior, seven of the children had already come to the attention of the court because of delinquency. (The first of these children, A. T. [case 3], is discussed above.)

Case 5. D. B., a 13-year-old boy, was initially seen after his mother had hit him with a broom, resulting in multiple contusions. The mother had been abusive to all seven of her children; she had also stabbed her husband five years previously. By age 17 the boy was known to the juvenile court because his behavior was out of control, he was running away from home, and he had broken probation.

Case 6. The father of G. S., an 11-year-old boy, threw battery acid at him, resulting in first and second degree burns on his face. One year prior to this event the child had fractured his leg when he "fell out of bed." Records noted that all six siblings had been known to have been abused. By age 15 he was known to the juvenile court because of his school difficulties, his truancy, and his uncontrollable behavior; he was on probation.

Case 7. S. S., a 15-year-old girl, had been beaten by her father with a heavy cord, resulting in multiple contusions and welts. The father was an alcoholic with at least one previous admission to a mental hospital; he was abusive to all eight children. By age 17 the girl was known to the juvenile court as a delinquent and a truant.

Case 8. B. S., an 11-year-old boy, was beaten by his father with a belt, resulting in soft tissue injury over the face and body. A similar incident had occurred eight years previously; records revealed a long history of abuse and neglect. The father was an alcoholic, and the mother was an alcoholic with a previous admission to a mental hospital. All siblings were known to have been abused at one time or another. By age 15 the boy was known to the juvenile court because of his behavior in school, his delinquency, and his truancy; he was also known to be enuretic.

Case 9. R. W., a nine-year, nine-month-old boy, had been beaten by his father with resulting soft tissue injury. The father had a previous admission to a mental hospital on record. By age 13, R. W. was known to the juvenile court because of assault with a deadly weapon, housebreaking, stealing, and breaking probation.

This theme, violence breeds violence, was painfully intimated recently in newspaper reports about the childhood of Sirhan Bishara Sirhan, the convicted assassin of Robert F. Kennedy. Teachers, pastors, and boyhood acquaintances who had known the subject in Jerusalem reported that he grew up in violence. Salim Awad, the headmaster of the Jerusalem Evangelical Lutheran School, was quoted as saying, "What the [school] records do not show is what went on at home. The father and mother had terrible fights, and the children suffered as a result. Their father beat them . . ."(9).

Pastor Daoud Haddad of the Lutheran Church of the Savior in Jerusalem stated that the father "had frequent violent fits and was given to breaking what little furniture they had, and beating the children. He thrashed them with sticks and with his fists, whenever they disobeyed him"(9).

Salin Atas, a boyhood acquaintance of Sirhan, related an incident when the father heated an iron and pressed it against Sirhan's heel. "I remember Sirhan coming to school with no shoes"(9).

All of these statements have an appalling resemblance to incidents and events in the families studied.

Discussion

A wide range of possible solutions is available to the child who has encountered violence. Special events in the child's life, personal experiences, or interpersonal relationships during the preschool period may lead to reparative intrapsychic defenses such as reaction formation, sublimation, and displacement. The authors would like to call attention to two extreme resolutions available to such children, for there is evidence that these two extremes represent clinically significant outcomes.

The longitudinal study of abused children and discussions with physicians and hospital house staffs suggest that some abused children cope with the emotional stress by choosing "identification with the aggressor" as their major defensive pattern.

Their model for identification and later for imitation shows poor impulse control in general and direct physical expression of aggressive impulses in particular. In addition, early childhood stresses and neglect result frequently in unmet dependency needs that result in oral or primitive patterns of interaction with people and with society.

Although not as easy to document, there are probably many abused children who "identify with the victim." Rather than becoming known to the courts as delinquents or criminals, these individuals become known as the victim: the wife-beater's wife, the person yoked, the person attacked and beaten. At an early age children who are repeatedly battered learn to sense when it is time to go outside, to leave the room, to be quiet. Through painful experience they have learned the consequence of allowing their parents to lose control. But there are other children who, under similar conditions, perform just the act or say just the word that precipitates a beating or abuse. These children seem to have learned that love equals being hurt, and they establish a pattern of inviting the role of harm and of playing the victim.

Milowe and Lourie(8) support this view. They feel that there may be factors in the personality development of some children leading to the child's inviting others to hurt him or to hurting himself, i.e., a "hurt and be hurt" relationship pattern. In another report, Milowe(7) reported the case of a child who was removed from his home because of repeated abuse and who was later abused by a foster parent.

Conclusion

Violence does appear to breed violence. A longitudinal study and review of family backgrounds over three generations shows that some abused children become the abusive parents of tomorrow. The child who experiences violence as a child has the potential of becoming a violent member of society in the future. The physician must be alert to the possibility of the child abuse syndrome; he must be willing to report such cases; he must be willing to join with his community agencies to help these children and their families. No other member of society has such a unique opportunity to interrupt this cycle of violence.

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